STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING _____ B. WING _____	C 06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CROSSING HEALTH & REHABILITATION CENTER	**3550 CENTRAL AVE COLUMBUS, IN 47203**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00150913.

Complaint IN00150913 - Unsubstantiated, due to lack of evidence.

Survey date: 6/26/2014

Facility number: 000572
Provider number: 155535
AIM number: 100267710

Survey team:
Julie Dover, RN - TC

Census bed type:
SNF: 57
SNF/NF: 57
Total: 57

Census payor type:
Medicare: 7
Medicaid: 47
Other: 3
Total: 57

Sample: 3

Willow Crossing Health and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00150913.

Quality Review 07/01/14 by Lisa McColly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE